



# A randomized controlled trial of a telehealth parenting intervention: A mixed-disability trial



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## ARTICLE INFO

**Keywords:**  
Parenting  
Disability  
Telehealth  
Online  
Online parent training  
Triple P Online-Disability

## ABSTRACT

**Background:** The quality of parenting a child receives has a major impact on development, wellbeing and future life opportunities.

**Aims:** This study examined the efficacy of Triple P Online – Disability (TPOL-D) a telehealth intervention for parents of children with a disability.

**Methods:** Ninety-eight parents and carers of children aged 2–12 years diagnosed with a range of developmental, intellectual and physical disabilities were randomly assigned to either the intervention (51) or treatment-as-usual (47) control group.

**Results:** At post-intervention parents receiving the TPOL-D intervention demonstrated significant improvements in parenting practices and parenting self-efficacy, however a significant change in parent-reported child behavioral and emotional problems was not detected. At 3-month follow up intervention gains were maintained and/or enhanced. A significant decrease in parent-reported child behavioral and emotional problems was also detected at this time.

**Conclusions:** The results indicate that TPOL-D is a promising telehealth intervention for a mixed-disability group.

## 1. Introduction

Problem behavior is one of the most enduring and pervasive challenges experienced by children with disability, their families, professionals, and the community at large. For families, problem behaviors such as tantrums, aggression and self-injury can be difficult to manage, emotionally distressing and disruptive to everyday routines, leading to increased stress, worry and depression (Einfeld, Tonge, & Clarke, 2013). For the children themselves, such behaviors can threaten personal health, safety and well-being as well as their inclusion in social, educational and community activities (Stuttard et al., 2014). With the prevalence of problem behaviors in children with intellectual or developmental disabilities being significantly higher than in typically developing children (Einfeld & Tonge, 1996), the unique combination of difficulties experienced can present a formidable set of challenges for parents and carers.

There is a growing consensus that the quality of parenting a child receives has a substantial impact on development, emotional functioning, language, social skills and future life opportunities (Stack, Serbin, Enns, Ruttle, & Barrieau, 2010). More specifically, positive parenting programs based on social learning and cognitive-behavioral principles have been found to be particularly effective in reducing emotional and behavioral problems in children and adolescents. Those that also incorporate ‘live’ (i.e., in-session) coaching of skills have been found to result in even greater gains in parenting skills and larger reductions in child problem behaviors

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<http://dx.doi.org/10.1016/j.ridd.2017.04.005>

Received 25 August 2016; Received in revised form 31 March 2017; Accepted 5 April 2017

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(Kaminski, Valle, Filene, & Boyle, 2008; Wade, Oberjohn, Conaway, Osinka, & Bangert, 2011). While reviews of parenting interventions specifically for children with developmental delay and/or disability are more limited, these have shown similar positive results (Antonini et al., 2014; Stuttard et al., 2014; Tellegen & Sanders, 2013; Whittingham, Sanders, McKinlay, & Boyd, 2014).

Given the efficacy of parenting interventions in improving child outcomes in both typically-developing children and children with a disability, it is unsurprising that programs that enhance parents' self-sufficiency in managing their children's behavior and environment have become a common route for early intervention. Despite both the availability and established effectiveness of evidence-based parenting programs, parent participation remains low (Sanders, Baker, & Turner, 2012). For parents, attendance in the traditional face-to-face modality has many well-documented challenges both logistical and personal, such as availability of alternative carers, cost, cultural barriers, perceived social stigma and so on (Breitenstein, Gross, & Christophersen, 2014; Enebrink, Högström, Forster, & Ghaderi, 2012). For service providers, common barriers to delivery include availability of funding; third party funding approval processes; availability of appropriately trained staff and geographical coverage issues (Love, Sanders, Metzler, Prinz, & Kast, 2013). With regular attendance at face-to-face parenting programs undoubtedly presenting a challenge for any parent, for parents of children with disabilities such barriers are likely to be further exacerbated by the need for specialized and/or additional resources associated with caring for their children.

With the clear need for more accessible treatment options, online parenting interventions offer the very real potential of helping to alleviate the burden of caring by providing 'anytime, anywhere' assistance to a parent or carer who has Internet access, predicated upon a basic level of Internet knowledge and expertise (Dittman, Farruggia, Palmer, Sanders, & Keown, 2014). While the empirical evidence remains limited, comparisons of online and (more broadly) telehealth parenting interventions with conventional face-to-face therapy have not only shown comparable outcomes in treatment results but have also indicated that these programs deliver parenting support in a manner that overcomes many of the traditional barriers to support, while maintaining high levels of client satisfaction (Enebrink et al., 2012; Sanders et al., 2012). Despite these encouraging findings, there remain few empirically validated parenting programs available in an online or telehealth delivery modality, and even fewer programs that specifically target, and/or include, adaptations to meet the specific needs of parents and caregivers of children with a disability (Antonini et al., 2014; Kable, Coles, Strickland, & Taddeo, 2012; Wade et al., 2014).

### 1.1. Research questions

The primary aim of the current study was to investigate the efficacy of a telehealth-based parenting intervention for parents of children with a disability. A 'treatment as usual' control group was chosen as the comparator to allow for evaluation of the intervention against current practice. Based on outcomes from similar in-person and telehealth-based parenting programs (Antonini et al., 2014; Brown, Whittingham, Boyd, & McKinlay, 2014; Enebrink et al., 2012; Roux, Sofronoff, & Sanders, 2013; Sanders, Dittman, Farruggia, & Keown, 2014; Sanders et al., 2012), the central hypotheses was that, compared to parents in a treatment-as-usual control condition, parents who completed TPOL-D would report a decrease in child behavior problems as well as significant improvements in parenting skills and self-efficacy. It was also hypothesized that intervention gains would be maintained at 3-month follow-up. Lastly, parent satisfaction with TPOL-D was also assessed using the Client Satisfaction Questionnaire (CSQ; Sanders, Markie-Dadds, & Turner, 2001).

## 2. Method

### 2.1. Study design

The study was a randomized, controlled trial following a 2 group (group: TPOL-D vs treatment-as-usual [TAU] control) × 3 time (time: pre-intervention [T1], post-intervention nine-weeks after initial login [T2], three-month follow-up [T3]) repeated measures design. Randomization was achieved using an online computer program ([www.randomization.com](http://www.randomization.com)). Pre-intervention measures (T1) were completed by both the intervention and TAU control group. The intervention group only then received the TPOL-D program. Post-completion of TPOL-D, both the intervention and TAU control completed T2 measures. Following completion of the post-treatment measures, the TAU control group also received TPOL-D. The TAU control received TPOL-D before follow-up data collection for ethical reasons. Post-intervention follow-up with the intervention group only was completed 3 months after TPOL-D completion (T3). Follow-up consisted of assessing treatment maintenance. While undertaking the study, all participants were asked not to participate in another parenting program, however, treatment-as-usual continued for both the treatment and the TAU control for ethical reasons. Fig. 1 depicts the flow of study participants in a CONSORT Diagram.

### 2.2. Participants

Power analysis indicated that to detect a large effect size of .8, with alpha set to .05 and power set to .80, a sample size of 26 participants per group would be required (Cohen, 1992). A large effect size was anticipated, based on a meta-analysis of Level 4 Triple P outcome research undertaken by de Graaf, Speetjens, Smit, de Wolff, and Tavecchio (2008a). Previous research has demonstrated a wide variance in relation to completion rates for online interventions (Baumeister, Reichler, Munzinger, & Lin, 2014; Bennett-Levy et al., 2010; van Ballegooijen et al., 2014) with, more specifically, a systematic review of digital delivery methods of parenting training interventions finding a completion rate of between 41.7% and 99.2% (Breitenstein et al., 2014). While a generous

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